VERMONT

ENBREL® (etanercept) - Prior Authorization and Patient Enrollment Form

Complete form in its entirety and fax to number listed below

1 PATIENT INFORMATION

Last Name	First Name	Middle Initial	
Date of Birth	Sex M ☐ F ☐	Medicaid ID #	
Allergies: ☐ NKA or _____			
Street Address	City		
State	County	Zip Code	
Home Phone	Cell Phone		
Parent/Guardian	Day Telephone	Night Telephone	
Emergency Contact	Relationship	Telephone	

2 PRESCRIBER INFORMATION

Prescriber's Name	NPI Number	DEA Number	
Telephone Number	Fax Number	Hospital/Clinic Name	
Street Address	City		
State	County	Zip Code	
Contact Person at Office	Prescriber Specialty		

Fax Completed Form to:

Fax Number: 866-364-2673

Phone Number: 800-327-1392

3 Office of Vermont Health Access ENBREL® (etanercept) PRIOR AUTHORIZATION REQUEST

Patient Diagnosis:

☐ Rheumatoid Arthritis ☐ Psoriatic Arthritis ☐ Juvenile Idiopathic Arthritis

☐ Ankylosing Spondylitis ☐ Plaque Psoriasis

If requesting prescriber is not a Rheumatologist or Dermatologist, has one of these specialties been consulted on this case? ☐ **Yes** ☐ **No**

Specialist name: _____ Specialist Type: _____

List previous medications/therapies tried and failed for this condition: (include oral, injectable, topical, phototherapy etc.)

Therapy (and dates)	Reason for discontinuation

Prescriber Additional Comments:

4 PRESCRIPTION

Dosage Form and Quantity:

☐ Enbrel 25 mg prefilled syringe Dispense Quantity: _____

or

☐ Enbrel 25 mg multi-use vial Dispense Quantity: _____

or

☐ Enbrel 50mg prefilled syringe Dispense Quantity: _____

or

☐ Enbrel 50mg SureClick autoinjector Dispense Quantity: _____

Sig: Dose/Route/Frequency:_____

Refill X:_____

Deliver product to: ☐ Patient's home ☐ MD office ☐ Clinic

Prescriber's Signature: _____ **Date:** _____

Last Updated 01/2009